South Carolina Workers' Compensation Commission
1612 Marion St.
P.O. BOX 1715
Columbia, SC 29202-1715
(803) 737-5675

WCC File #: _____
Carrier File #: _____
Carrier Code #: _____
Employer FEIN #: _____

Claimant's Name: _____ SSN: - - Employer's Name: _____

Address: _____ Address: _____

City: _____ State: _____ Zip: _____ City: _____ State: _____ Zip: _____

Home Phone: ( ) - Work Phone: ( ) - Carrier: _____

Preparer's Name: _____ Preparer's Phone #: ( ) -

Provide the information requested in the space provided. Use an additional sheet, if necessary. Type or print all information.

☐ Injury by Accident ☐ Occupational Disease ☐ Both Injury by Accident and Disease ☐ Other

1. Date of Accident: _____ 2. AWW: $ _____ Compensation Rate: $ _____
3. Type of injury and body part(s): _____
4. Facts in controversy: _____
5. Legal issues involved: _____
6. Unusual problems: _____
7. Witnesses (designate if expert):* _____
8. Exhibits: _____
9. Medical evidence (indicate report pursuant to R.67-612; deposition or appearance):
10. Name, address, and specialty, if any, of the treating physician: _____
11. Impairment rating(s); body part(s); physician and date of opinion: _____

SIGNATURE _____

DATE OF HEARING _____ TIME OF HEARING _____

On behalf of ☐ Claimant ☐ Employer

File this form and proof of service on the opposing party according to R.67-611 and R.67-212. Do not send medical reports.
* Commissioners reserve the right to admit expert witnesses at hearings.